UPDATE OCTOBER 12: Avalere, a health consulting company doing business in the health insurance exchange space, reports that 24 states and DC now have submitted a essential health benefits benchmark plan to the federal government under the DHHS "soft" deadline. The states are shaded in the map below.

September 30, 2012, was the deadline for states to submit to the federal government the essential health benefits that in essence will be the minimum benefits for individual and small group health insurance plans offered both inside and outside the health insurance exchanges called for under federal health care reform. Only 20 states and the District of Columbia have made their decisions according to an article in the October 4 FierceHealthPayer.

States looked at plans already popular in their marketplaces. Small employer plans were selected by 15 states. Connecticut, Michigan and North Dakota chose an HMO plan, while Utah and Maryland selected a state employee plan.

Some governors complained that the federal government has not provided sufficient guidance. Indiana’s Governor Daniels delayed the decision until a new governor is elected in November according to the Northwest Times.

HHS officials have called the deadline a “soft” one since there is no applicable federal regulation. The Commonwealth Fund reports that in correspondence with Kansas, Secretary Sebelius said that DHHS would reach out to states that did not submit the benchmarks to work on a default plan. Eventually, if a state fails to set essential health benefits standards, the U.S. Department of Health and Human Services could do so.

In December 2011, the federal government released the ten essential health services that must be in small group and individual plans offered for purchase within a state, whether through the exchange or within the open marketplace. They are:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

States were given flexibility on which specific services and benefits within each category would be covered and what levels of co-insurance would be allowed. Plans must meet the designated minimum. Other plans can provide benefits richer than the minimum and will be certified as silver and gold level plans.

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